

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040129

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9489

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED OCT 29 1962

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)

Inside Limits

HOSPITAL OR
INSTITUTION

City Hospital No. 1

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

St. Louis

admission)

c. CITY
OR
TOWN

St. Louis Mo

Inside Limits

Yes ☐ No ☐d. STREET
ADDRESS

912 Elliott St.

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

PRICE

CUNEGIN

4. DATE
OF
DEATH

Month

Day

Year

Sept

25

1962

5. SEX

Male

6. COLOR OR RACE

Color

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

UNKNOWN

9. AGE (last birthday)

56

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SHIP YARD

10b. KIND OF BUSINESS OR INDUSTRY

SHIP YARD

11. BIRTHPLACE (City and state or country)

ALA

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

UNKNOWN

13b. MOTHER'S MAIDEN NAME

UNKNOWN

14. NAME OF HUSBAND OR WIFE

L. Cunegin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of serv)

NO

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

1 Deborah Brewer Rutgerha

Address

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hemorrhage secondary to

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Varicosities of the Esophagus which

DUE TO (c)

Was result of Cancers.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

581.0

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. ACCIDENT ☐SUICIDE ☐HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

to

and last saw her
him alive on

Death occurred at

m

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

MS CLAIN

1841 CASS

OCT 4 1962

Carl Smith MD

USE BLACK INK
OR
TYPEWRITER RIBBON

Not Embalmer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *O. Mc Clain*

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.